Exploring help seeking behaviour in health: are gender binaries useful?

Gillian M. Martin BA(Melit.) MSc (Manchester) PhD (Manchester)

Lecturer, Dept. of Sociology,
Faculty of Arts, University of Malta.
Email: gillian.martin@um.edu.mt

Educational aims

- To highlight the relevance of the phenomenological or 'lived' body in Health and Illness
- To highlight fluid ambiguity within gender stereotype associations in help seeking behaviour
- To problematize the use of binary gender oppositions within health/medical research

Key words
Gender, health, help seeking behaviour

Abstract

While positivistic research uses male/female, sex or gender as the independent variable to highlight its associations with health experience, qualitative research shows that binary notions of male/female sex and gender are sometimes insufficient markers of lived reality. This article aims to highlight gendered aspects of the consultative relations that have been shown to have an impact on subsequent medical care provision. It outlines the dynamics within consumer/medical professional relations that are impacted by gender stereotype associations using cardiac symptoms as an example, and then goes on to problematize the binary concept of gender and its impact on health care provision.

Introduction: community pharmacists and consultative relations

"Pharmaceutical care is the pharmacists' contribution to the care of individuals in order to optimize medicines' use and improve health outcomes".[1] This definition neatly puts the community pharmacist's relations with the health seeking individual at the focus of practice where the pharmacy professional is a potential collaborator within a multi-disciplinary team. Comparative Europe-based research has shown that pharmacists in Malta rated highly in the provision of referral and consultation activities.[2] Their willingness to provide this aspect of care has also been highlighted[3] and empirical work has also shown that this consultative/referral role is one that consumers in Malta are in favour of with 91% showing a preference for the extension/development of the community pharmacists' role in liaising with primary and secondary care-based physicians.[4]

With this key aspect of a community pharmacist's role at the forefront, this article aims to highlight gendered aspects of the consultative relations that have been shown to have an impact on subsequent medical care provision. It sets out to outline the dynamics within consumer/medical professional relations that are impacted by gender stereotype associations using cardiac symptoms as an example, and then will go on to problematize the binary concept of gender and its impact on health care provision.

Gender and health

The association of gender with quality of health is a key area of focus in medical sociology. Cultural, educational and economic factors and their frequent negative association with the female gender have been shown to compromise women's

health worldwide.[5, 6] The World Health Organisation (WHO) hosts a programme dedicated to gender equity in health care and to promoting "health professionals' awareness of the role of gender norms, values, and inequality in perpetuating disease, disability, and death [...]".[7] The importance of flagging these structural sources of gender-associated health inequity is clear and warrants highlighting at the start. The aim here, however, is to zoom in from this broad view and use an interpretive micro perspective to focus on the relational dynamics within client/medical professional interactions and the consequent impacts on health care and medical intervention. Doing this throws an interesting paradox into relief.

While macro scale positivistic research uses male or female sex or gender as the master status and independent variable to highlight its associations with health experience, qualitative research shows that binary notions of male/female sex and gender are sometimes insufficient markers of lived reality.[8]

The bio-physical body and the 'lived' body

Medical consultations with health seeking individuals focus on the bio-physical body (female or male sex would be relevant here) and its intertwining with the lived, phenomenological body (female, male or other gender would be relevant here). This intertwining of *korper* and *leib*, bio-medical and lived body,[9, 10] is what makes the field of health and illness so interesting and challenging from a sociological point of view. As medical professionals assessing and prioritising the needs of help seeking individuals, community pharmacists would be influenced by knowledge of epidemiology and bio-medical risk factors. They would also be influenced by culturally engrained suppositions and role expectations. The sex and gender of the help-seeking individual have been shown to have an important influence in both of these respects.

Coronary heart disease - gender and 'candidacy'

Focusing on a patient presenting with cardiac symptoms offers a good opportunity to highlight the issue. Coronary Heart Disease (CHD) is entrenched within medical discourse as a disease typically linked to mid-life males. The bio-medical and socially rooted risk factors, and the elevated death rates in the male population[11] have led to a heightened preoccupation with prevention measures, screening and follow-up of this group. Research focusing exclusively on white, middle-aged men in America in the 1950s identified a pattern of behavioural responses to stress which linked the risk of myocardial infarction with the (white) male, workaholic executive – the 'hypermasculine Type A man' as described by cardiologists Rosenmann and Friedman.[12] Despite its being debunked in the wake of more socially diverse and sex/gender sensitive empirical work in the 80s and 90s, the impact of this work is that it contributed to the entrenchment of the masculinist discourse of CHD which still has important consequences.

This predominant association of bio-medical and social/cultural risk factors and the male sex creates an expectation of 'candidacy' of the individual presenting with cardiac symptoms that may have an impact on the medical professional's management decisions - the implication being that women are seen to be unlikely candidates for CHD when seeking medical advice.[13]

Gender and help seeking behaviour

The consultation dynamics between help seeking individuals and health professionals are further compounded by stereotypical concepts of gendered responses to symptoms. There is a 'strong public narrative' that men will delay seeking help in situations of health threatening symptoms – that they will do the 'manly' thing and be brave and stoic, only seeking help when the situation is serious – thereby maintaining and further cultivating the hegemonic masculine traits of denial of weakness and vulnerability.[14, 15] Detailed discussion of these complex power dynamics and the social construction of 'masculine' health behaviour is beyond the scope of this article. It is important, however, to flag the over-simplistic binary deduction that if men don't seek help until a situation is serious, then women do.

This assumption leads to the interesting point that women are less likely to be seen as candidates for coronary disease by medical professionals when describing their symptoms – a fact confirmed by Arber *et al* (2006) who found that "gender significantly influenced doctors' diagnostic management activities [...] women were asked fewer questions, received fewer examinations and had fewer diagnostic tests ordered for CHD [when presenting with CHD symptoms]".[16] This may seem to be the expedient evidence-based response conditioned by positivistic research on CHD risk factors as linked to sex (focusing on the *korper* or anatomo-physiology of the body); or would it be better described as the acknowledgement of gendered health behaviour and social construction of illness? (focusing on the *leib* or 'lived body'). Rather than using a categorical 'either/or' dichotomy, a relational approach would be 'both/and' – one that recognises the mutually constructive processes, where sex and gender are 'simultaneously biological and social'.[8]

Conclusion

"Categorical thinking persistently underplays diversity *within* the gender categories"[17] – diversity that is rooted in differences in education, age, social class, ethnicity to mention the key examples.[17, 18]

The key point being made here is that these binary oppositions of biology vs. social environment, sex vs. gender, female vs. male are misleading and self perpetuating. The challenge of contemporary medical sociology is to focus on the blurred fluid boundaries of these false binaries, to highlight

"*the entanglement of sex and gender in human health research and articulate good practice guidelines for assessing the role of biological processes- along with social and bio-social processes- in the production of non-reproductive health differences between and among men and women*".[8]

Key points

- Dynamics within help seeking individual/medical professional relations may be impacted by gender stereotype associations.
- Binary notions of male/female sex and gender are sometimes insufficient markers of lived reality.
- Binary oppositions of biology vs. social environment, sex vs. gender, female vs. male are misleading and self perpetuating.
- Rather than using a categorical 'either/or' dichotomy, a relational approach would be 'both/and' – one that recognises the 'mutually constructive processes', where sex and gender are 'simultaneously biological and social'.

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